SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
Rehabilitation Supports

MEDICAL NECESSITY STATEMENT

Please Type or Print

Person's Name:
Date of Birth:
Social Security Number:
Medicaid Number:

Medical Necessity Criteria for Rehabilitation Supports: The person is a Medicaid recipient and meets DDSN eligibility criteria, who needs to develop, retain or restore an optimal level of functioning in one or more of the following areas: Self-Care Skills; Community Living Skills; Psycho-Social Skills; and/or Medication Management / Symptom Reduction Skills; in order to enhance the person's capacity for personal independence essential for successful community living.

☐ Approve. I recommend that the above-named person be provided Rehabilitation Supports for the purposes of correcting or ameliorating physical or functional limitations and/or mental illnesses and/or other conditions which, if left untreated, would negatively impact the health and quality of life of the person. The person meets the medical necessity criteria for Rehabilitation Supports.

☐ Deny. I do not recommend that the above-named person be provided Rehabilitation Supports. The person does not meet the medical necessity criteria for Rehabilitation Supports.

Signature of Physician or Licensed Practitioner of the Healing Arts:	Professional Title:
Name of Physician or Licensed Practitioner of the Healing Arts:	Date:
Address:	